BONE HEALTH QUESTIONNAIRE

Marci Goolsby, M.D.

Patient Name:_____

Have you ever had a fracture (broken bone)? ○ YES ○ NO
If so, what bone and when? _____
Have you ever had a stress fracture? ○ YES ○ NO
If so, what bone and when? _____
If you currently have a stress fracture, what has been done for your treatment?
Activity allowed: _____
Medications: _____
Bone stimulator: _____
If you have pain with activity, at which point? i.e. during activity, after activity, all the time?
_____

Menstrual History:
How old were you when you started your period? _____
Do you get regular periods every month? ○ YES ○ NO
If no, how many days between your periods? _____
How many periods have you had in the last 12 months? _____
Are you on birth control pills or have an IUD in place? ○ YES ○ NO
If yes, which and for how long? _____
In the past, did you ever have irregular periods? ○ YES ○ NO
If yes, please describe: _____
Have you ever been pregnant? ○ YES ○ NO
If so, how many times? _____ How many children do you have? _____

Diet History:
Have you ever dieted? ○ YES-Describe_____ ○ NO
Is there anything you avoid eating? ○ YES-Describe_____ ○ NO
Have you ever taken diet pills or laxatives? ○ YES-Describe_____ ○ NO
Have you ever made yourself vomit? ○ YES-Describe_____ ○ NO
Do you binge eat? ○ YES-Describe_____ ○ NO
Do you exercise excessively to lose weight? ○ YES-Describe_____ ○ NO
Has your weight fluctuated over the last few years? ○ YES-Describe_____ ○ NO
What is your highest weight in the last 5 years? _____
What is your lowest weight in the last 5 years? _____
Please describe in detail an average day's food and drink intake:_____
_____
_____
_____

Medical History:

Do you have celiac disease? ○ YES ○ NO
Do you not tolerate or avoid certain foods? ○ YES ○ NO
Do you have ongoing stomach or digestion problems? ○ YES ○ NO
Have you had any thyroid problems? ○ YES ○ NO
Have you ever had a kidney stone? ○ YES ○ NO
Please list any prescription medications you take: _____
Please list any over the counter medications or vitamins or supplements you take, including pain medicine: _____
Do you take calcium and/or vitamin D pills or chews? ○ YES ○ NO
If so, which kind and how often? _____
Do you have osteopenia or osteoporosis? ○ YES ○ NO
Have you ever had a bone density test (DXA scan)? ○ YES ○ NO
If so, when? _____
Have you ever been a smoker or heavy drinker? ○ YES ○ NO
If so, how many a day and for how long? _____

Family History:

Osteoporosis ○ YES-Describe_____ ○ NO
Hip fracture ○ YES-Describe_____ ○ NO
Bone disease ○ YES-Describe_____ ○ NO
Kidney stones ○ YES-Describe_____ ○ NO
Parathyroid disease ○ YES-Describe_____ ○ NO
Eating disorder ○ YES-Describe_____ ○ NO
What is your ethnic background?_____

Training History:

Please write out your typical exercise routine and include duration or distance of each activity and times per week._____
_____
_____
_____
How many days per week do you rest from exercise, if any? _____
How long have you had your current running shoes? _____
If you wear orthotics/shoe inserts, how long have you had these? _____
Have you ever had a gait analysis? ○ YES ○ NO
Do you experience more fatigue than you would normally expect? ○ YES ○ NO

Signed by patient:_____ **Date:**_____

Reviewed by Dr. Goolsby:_____